

Arkansas Access to Recovery – Exception Request Form
Please fax to: 501-682-9901

Date Requested:	Provider Name:
Client Name:	Provider Staff:
Client ID Number:	Provider Telephone Number:
Client Start Date:	Provider FAX Number:

Exception Requested:

FUNDS DETAIL

Amount vouched to date: \$ _____ **Amount expended to date** \$ _____

Services rendered to date: _____

What other funds have been investigated/utilized for this client? _____

☐ Recovery / Treatment Plan attached (required)

What makes this client more deserving than other clients for an exception? In other words, what unique circumstances specific to this client support the need for additional funds? Examples: (a) the client has 7 children (b) the client is sole caregiver for elderly, handicapped, etc. (b) house burned or was lost (c) family member was tragically killed (d) proven success in recovery lacks only a small more assistance, etc. (Attach a separate page, if necessary).

Care Coordinator signature _____ **Date** _____

Approved: _____ **Date** _____

Title _____ **Dept.** _____